IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8934

July 24, 2006

Josiah Dahlstrom, Administrator
Beacon Rehabilitation of Pocatello
1200 Hospital Way
Pocatello, ID 83201

Provider #: 135071

Dear Mr. Dahlstrom:

On **June 29, 2006**, a fire safety survey was conducted at Beacon Rehabilitation of Pocatello by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the**

CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 7, 2006.** Failure to submit an acceptable PoC by **August 7, 2006**, may result in the imposition of civil monetary penalties by **August 28, 2006.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 3, 2006 (Date Certain).** Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 3, 2006.** A change in the seriousness of the deficiencies on **August 3, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 3, 2006** includes the following:

> Denial of payment for new admissions effective **September 29, 2006.** [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 29, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 29, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 7, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 7, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd for

MARK GRIMES
Supervisor
Facility Fire Life Safety and Construction

MG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V(111) construction with a large basement. The facility was originally built/completed on 6/1/1970. A refurbishment was completed in 2000. It is fully sprinklered and has complete smoke detection in corridors and open spaces. Currently it is licensed for 12 psychiatric hospital beds and 84 SNF/NF beds. The following deficiencies were cited during the annual Fire Life Safety survey conducted on 28-29/06/2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 3/11/2003, in accordance with CFR 42, 483.70. The Survey was conducted by: Debra Ransom, RN, RHIT Team Leader Keith Barkow, Health Facility Surveyor Chris Laumann, Health Facility Surveyor	K 000	RECEIVED AUG 03 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Josiah Dahlstrom — TITLE: Administrator — (X6) DATE: 8/2/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to ensure compliance in maintaining the corridor walls of the facility in a state to resist the passage of smoke. This effected all residents residing within 1 of the 2 smoke compartments. Findings include: 1.) During a facility tour on 6/28/2006 at 3:10 PM it was observed that a two foot long tear in the corridor wall had occurred along the guard rail outside the kitchen area resulting in the compromise in the smoke resistive barrier. Observations were witnessed and noted by Maintenance staff	K 017	**K 017** The crack in the corridor wall along the guard rail has been repaired. It has been sealed to prevent smoke passage into the wall and kitchen. Our maintenance department will inspect the entire building and repair any other holes or cracks. This had the potential of affecting all residents. All staff has been in-serviced on the danger of penetrations to the smoke barrier and have been instructed to identify penetrations and report to the maintenance department for repair. Training on penetrations and the maintenance request log will be done in new employee orientation with all new employees. The maintenance request logs will be reviewed by the administrator weekly and any concerns will be brought to the monthly CQI meeting.	08-03-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations found during a facility tour it was determined that the facility failed to ensure the proper closure and latching of corridor doors. 9 of 26 resident rooms were effected. The finding included: 1.) During a facility tour of the facility on the afternoon of 6/28/06, between the hours of 2:40 PM and 3:45 PM, the following doors were observed to not properly seal when closed: Rooms 7, 11,12, 18, 19, 26, 22, 35, and 37.	K 018	**K 018** The doors to rooms 7, 11, 12, 18, 19, 26, 35, and 37 have been repaired. These doors all seal properly when closed. This had the potential of affecting all residents. Maintenance staff will conduct an inspection of all remaining doors and initiate repair of any problems noted to ensure that all doors seal properly when closed.	08-03-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 Observations were witnessed and noted by survey team and facility maintenance supervisor.	K 018	**K025** The holes found in the social Worker's office and also in the DNS's office have repaired in order to provide the smoke barrier as required by federal regulation. This had the potential of affecting all residents. The entire building was also audited by the maintenance staff to locate holes of a smaller diameter that may have been overlooked during the survey and each of these holes have also been filled in. Maintenance staff will conduct an inspection of all remaining areas and initiate repair of any penetrations to ensure that the integrity of the smoke barrier is maintained. Staff have been in-serviced on the danger of penetrations to the smoke barrier and have been instructed to identify penetrations and report to the maintenance department for repair. Training on penetrations and the maintenance request log will be done in new employee orientation with all new employees. The maintenance request logs will be	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to maintain the ceilings of the building in a state to resist the passage of smoke. This had the potential to effect all residents in one of two smoke areas. Findings include: 1.) During a facility tour on 6/28/2006 at 3:00 PM, it was observed that a 2 in hole in the ceiling in the Social Worker's office left a penetration in the smoke barrier as Computer wires protruded through the hole. In accordance with NFPA 101 Life Safety Code section 8.3, smoke barriers are constructed to provide at least a one half hour fire	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 4 resistance rating. 2.) During a facility tour on 6/28/2006 at 3:10 PM, it was observed that numerous 1/2 in holes in the ceiling of The Director of Nursing's office which left penetrations in the smoke barrier. In accordance with NFPA 101 Life Safety Code section 8.3, smoke barriers are constructed to provide at least a one half hour fire resistance rating. Observations were witnessed and noted by survey team and facility maintenance supervisor.	K 025	reviewed by the administrator weekly and any concerns will be brought to the monthly CQI meeting Any issues revolving around puncturing the smoke barrier will be brought to CQI meeting monthly and addressed.	08-03-06
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the corridor was free of equipment not in immediate use. The findings included: On 6/28/06 at 4:20 PM it was observed that lift equipment were permanently being stored in the corridor outside the nurses station on Cape May. Nursing staff stated at the same date/time of the observation that the lift equipment were permanently stored in this area. The area had a permanent sign labeling the area as, "lifting	K 039	**K 039** A closet on Cape May has been converted to a parking area for lifts. The sign that read "lift machine parking area" was removed and placed on the appropriate storage area. This will ensure the corridor remains free of equipment not in immediate use. This had the potential of affecting all residents. Staff has been in-serviced on the proper storage of lifts and other equipment and the importance of keeping corridors free from obstructions. The shift supervisors and charge nurse on Cape May will be responsible to provide feedback and on-going training to staff regarding equipment storage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 039	Continued From page 5 machine parking area", therefore the placement of the equipment was not temporary. The equipment placement in the corridor placed a restriction on exit access and did not allow full use of the corridor during an emergency/fire. Observations were witnessed and noted by survey team and facility maintenance supervisor.	K 039	Shift supervisors will monitor corridors for equipment and will provide a report in the monthly CQI meeting.	08-03-06
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on staff interview, the facility failed to ensure dietary staff who were knowledable about proper emergency procedures in case of a fire. This effected the three of three kitchen staff who were present at the time of the survey. This had the potential to affect 100 percent of the residents. Findings include: Interview with kitchen staff revealed that they did not know what to do in case of a fire in the	K 050	**K 050** The dietary staff members have been in-serviced on emergency procedures in case of a fire. Inservice training in fire procedures has also been provided for staff members of all other departments. Emergency procedures will be covered during Day 1 of our new employee orientation and that training will be documented in each employee personnel file. The HR director will be conduct audits of personnel files and inform supervisors of any employees missing the required training. Each department head will also be required to provide orientation to the fire policy specific to their work environment. The HR department will report on the status of emergency training to CQI meetings.	08-03-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 6 kitchen. In addition they could they identify the location or appearance of the pull handle to activate the fire suppression system.	K 050	**K 054** New Tech Security Systems has completed an inspection and has completed necessary repairs to the fire system. All smoke detectors have been inspected and repaired as necessary. The maintenance supervisor will conduct a monthly visual inspection of all smoke detectors and will provide this report to the administrator. The fire system will be inspected annually by a third party company specializing in fire service. The reports for the monthly and annual inspection will be reviewed in CQI meeting.	08-03-06
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to ensure smoke detectors are in working order and maintained . This had the potential to affect all residents within 1 of 2 smoke compartments. Findings include: 1.) On facility tour on 6/28/06 at 3:03 PM a broken smoke detector was found hanging from the ceiling in The Social Worker's office. Observation was witnessed and noted by survey team and facility maintenance supervisor.	K 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based upon observation of portable fire extinguishers, the facility failed to maintain installed portable fire extinguishers as required by the Life Safety Code and NFPA Std 10. This effected all residents serviced by Nursing Station. Findings Included: On 6/28/06 at 4:25 PM in the Cape Elizabeth nurses station, it was observed that a fire extinguisher was not mounted. The extinguisher was found sitting on the ground behind the wall. This finding was witnessed and noted by survey team and facility maintenance supervisor.	K 064	**K 064** The portable fire extinguisher from Cape Elizabeth that was found sitting on the ground has been mounted on the wall. All other fire extinguishers have been inspected and are currently properly mounted on walls. Staff have been in-serviced to ensure that all fire extinguishers remain properly mounted. The maintenance supervisor will conduct monthly inspections to ensure proper mounting of fire extinguishers and the results will be presented in CQI meeting.	08-03-06
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that there was no permanent use of extension cords, and to ensure that proper covers were placed over outlets and	K 147	**K 147** 1-The broken or missing outlet covers in the training room, room 10, and room 12 have all been replaced. 2-The circuit breaker covers in the basement electrical panel have been replaced. 3- The extension cord in room 13 has been removed. The staff have been in-serviced identifying the problems listed above and the procedure to notify the maintenance department of problems.	08-03-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 8 circuit units. The facility had 84 beds and all residents were effected. Findings included: 1. During facility tour on 6/28/06 between 2:31 and 2:55 PM electrical outlet covers were observed to be missing in the following locations: a)training room. b)Room 10 c)Room 12 2. At 3:44 on 6/28/06 in the basement an electrical panel was observed to be missing 2 circuit breaker covers. 3. One instance of permanent use of extension cords was observed in room 13 at 3:00 pm on 6/28/06. NFPA 70, National Electrical Code. 9.1.2 states that extension cords are for temporary use only.	K 147	**K 154** The facility Fire Watch policy and procedure have been reviewed and modified and department heads and supervisors have been in-serviced on this policy.	08-03-06
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by:	K 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 154	Continued From page 9 Based on staff interview and record review the facility failed to have a policy/procedures in place to address either a planned or unplanned fire alarm system shutdown. Findings same as K-155	K 154	**K 155** See response to K 154	
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to have written policy and procedures to address either a planned or unplanned sprinkler system outage. Findings include: Interview with the maintenance supervisor on 6/29/06 at 11:00 AM revealed that the facility did not have a written policy or procedures related to implementing a fire watch. Interview with the facility Administrator on the afternoon of 6/29/06 confirmed that the facility did not have written documentation of a fire watch program. Staff was aware of what to do, but no formal procedures were written for the facility.	K 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 10 Findings were witnessed and noted by maintenance supervisor	K 155		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, type V(111) construction with a large basement. The facility was originally built/completed on 6/1/1970. A refurbishment was completed in 2000. It is fully sprinklered and has complete smoke detection in corridors and open spaces. Currently it is licensed for 12 psychiatric hospital beds and 84 SNF/NF beds. The following deficiencies were cited during the annual Fire Life Safety survey conducted on 6/29/06. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Debra Ransom, RN, RHIT Team Leader Keith Barkow, Health Facility Surveyor Chris Laumann, Health Facility Surveyor	C 000	RECEIVED AUG 03 2006 FACILITY STANDARDS	
C 229	02.106,02,a LIFE SAFETY CODE REQUIREMENTS 02. Life Safety Code Requirements. The facility shall meet such provisions of the Life Safety Code of the National Fire Protection Association (26th ed., 1985) as are applicable to a health care facility except: a. As modified herein, the facility shall comply with the standards for "Health Care	C 229		

Bureau of Facility Standards

Josiah Dahlstrom — Administrator

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 229	Continued From page 1 Occupancies" contained in Chapters 12 and 13, and applicable provisions of Chapters 1 through 7, Chapter 31, and Appendices A, B, and C of the Life Safety Code; or This Rule is not met as evidenced by: Refer to K 018 as it relates to proper closure of cooridor doors. Refer to K 018 as it relates to the maintance of smoke barrier.	C 229	**C 229** See response to K 018	8-3-06 CDZ
C 243	02.106,05 ORIENTATION, TRAINING & DRILLS 05. Orientation, Training and Drills. All employees shall be instructed in basic fire and life safety procedures. This Rule is not met as evidenced by: Refer to K050 as it relates to staff training in the event of a fire in the kitchen.	C 243	**C 243** See response to K 050	8-3-06 CDZ
C 253	02.106,07,a a. The use of any defective equipment on the premises of any facility is prohibited. This Rule is not met as evidenced by: Refer to K 054 as it relates to the facility's failure to ensure that the smoke detectors were maintained and functional.	C 253	**C 253** See response to K 054	8-3-06 CDZ
C 436	02.120,10,e e. All patient/resident personal electrical appliances shall be inspected and approved by the facility engineer and/or administrator. This Rule is not met as evidenced by: Refer to K147 as it relates to the use of extension	C 436	**C 436** See response to K 147	8-3-06 CDZ

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135071	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON REHABILITATION OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 436	Continued From page 2 cords.	C 436		8-3-06 ck